04208

Evidence for addition of name of town of death is shown on FILM No. G 95 JUN 16 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 282

1. PLACE OF DEATH:

County: St. Mary's

City or town: Valley Lee

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: St. Mary's

City or town: Valley Lee, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Maude Roselie Campbell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	married

B.(b) Name of husband or wife: Lewis Campbell

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): June 7 1896

8. AGE: Years	Months	Days	If less than one day
48	10		hrs. min.

9. Birthplace: Valley Lee, St. Mary's Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Mason

13. Birthplace: St. Mary's Co. Md.

MOTHER — 14. Maiden name: unknown

15. Birthplace

16. Informant: Helen Cecelia Campbell Dickens

Address: Piney Point, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 13th 1945 (month) (day) (year)

Cemetery or crematory: St. George's

Location: Valley Lee Md.

18. Funeral director: W. C. Mattingley Sons

Address: Leonardtown Md.

19. 4/12/1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11th 1945, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1944 to April 11 1945 and that I last saw h... alive on April 10 1945

Immediate cause of death	DURATION
Myocardial failure	ca 2 wks
Due to: Chronic myocarditis and	Several
Due to: myocardial degeneration	yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert T. Funk, M.D. (M. D. or other)

Address: Leonardtown, Md. Date signed 4/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

04209

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:
County St. Mary's
City or town Rural, Park Hall
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County St. Mary's
City or town Rural Park Hall
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Francis Carroll

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Single

8.(b) Name of husband or wife
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) April 19, 1945

8. AGE: Years	Months	Days	If less than one day
—	—	3	hrs. min.

9. Birthplace Park Hall Md
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name John Reed
13. Birthplace Maryland

MOTHER
14. Maiden name Sarah Carroll
15. Birthplace Park Hall Md

18. Informant Grace Carroll
Address Park Hall

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-24-45 (month) (day) (year)
Cemetery or ~~crematory~~ St. James
Location Park Hall Md
10. Funeral director Charles Somerville
Address Park Hall Md.

19. 4-23-1945 (Date rec'd by registrar) P J Beam MD Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1945, at 11:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4th 1945 to 19
and that I last saw h alive on Sealed 19

Immediate cause of death	DURATION
Premature birth (8 month)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE P J Beam M.D.
M. D. or other
Address Great Mills Md Date signed 4-23-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 122-a

04210

CERTIFICATE OF DEATH

Reg. Dist. No. 2-84

1. PLACE OF DEATH:
County St Marys Leonard Town
City or town Mechanicsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? St Marys Hospital
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? Four hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County St Marys
City or town Mechanicsville Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Delphia Colone.

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Wh.	Widow.

6.(b) Name of husband or wife H. A. Colone.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Jan 3 - 1874

8. AGE: Years	Months	Days	If less than one day
71	3	20	..... hrs. ..... min.

9. Birthplace St Marys Md
(Town, county, and state)
10. Usual occupation Houseworker
11. Industry or business

FATHER
12. Name Jeremiah Davis
13. Birthplace St Marys Co Md.

MOTHER
14. Maiden name Caroline Carter
15. Birthplace St Marys Co Md.

16. Informant Charley Colone.
Address Wash - D C

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 25 '45
(month) (day) (year)
Cemetery or crematory Oak Hill.
Location Mechanicsville
18. Funeral director Elmer M Thomas.
Address Hughesville Md

19. Apr 24 1945 Lem J Sothoron
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1945, at 8 P, M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1st 1945 to April 23 1945
and that I last saw h... alive on April 1945

Immediate cause of death	DURATION
	5 Yrs.
Due to Myocarditis.	
Due to Strangulated Hernia	4 Days.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Lem J Sothoron
M. D. or other
Address Charlotte Hall Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M) (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 64

04211

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:

County: St. Marys

City or town: Dameron
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: St. Marys

City or town: Dameron
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Amanda Jane Dameron

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 14th 1857

8. AGE: Years	Months	Days	If less than one day
87			..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: James Railey
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary E. Taylor
15. Birthplace: Maryland

16. Informant: J. Spencer Dameron
Address: Dameron, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 /19/ 45 (month) (day) (year)

Cemetery or crematory: St. Michaels

Location: Ridge, Maryland

18. Funeral director: E.L.Robinson

Address: Dameron, Maryland

19. 4-17- 1945 (Date rec'd by registrar) P J Beany MD Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16th 1945, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 7 1945, to April 16 1945, and that I last saw h.. alive on April 15 1945

Immediate cause of death	DURATION
Coronary sclerosis	3 years
Due to: Cerebral arterio sclerosis	10 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: P J Beany M.D. M. D. or other

Address: Great Mills, Md. Date signed 4-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

04212

CERTIFICATE OF DEATH

Reg. Dist. No. 2-87

1. PLACE OF DEATH:

County: St. Mary's County

City or town: US NAS Patuxent River, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months

Hospital, institution, or street address where death occurred:
Dispensary, US NAS Patuxent River, Md.

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: South Carolina County:

City or town: Rt. 1, Box 166, Camden, S.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: HENRY, Marvin Petty Service number 552-35-64

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 17, 1925

8. AGE: Years	Months	Days	If less than one day
20	2	21	hrs. min.

9. Birthplace: South Carolina
(Town, county, and state)

10. Usual occupation: Aviation Machinist Mate

11. Industry or business: U. S. Navy

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: U. S. N.
Address

17. Transportation (Burial, cremation, or removal. Which?) Date thereof 4-9-45 (month) (day) (year)

Cemetery or crematory:

Location: Camden, South Carolina

18. Funeral director: P.B. Robinson's Funeral Home
Address: Leonardtown, Maryland

19. 4/9/1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 April 1945, at 4:28 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 March 1945, to 7 April 1945 and that I last saw him alive on 7 April 1945

Immediate cause of death	DURATION
Choroiditis, acute	
Due to Hyperthermia (typhoid): produced by the therapeutic administration of triple typhoid vaccine.	
Due to Suppression of Urine, acute (Uremia): due to hepatorenal shock. Duration: 48 hours.	
Other conditions: c.w.s.r.	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

R. H. Driscoll

23. SIGNATURE: R. H. DRISCOLL, Lt. (MC) U.S. Navy
M. D. or other

Address: NAS Patuxent River, Md. Date signed: 4-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

04213

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County: St Marys

City or town: Holly Wood Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: St Marys

City or town: Hubbly Wood Md R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Oliver Jacobsen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Elaine Jacobsen

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): October 9 1884

8. AGE: Years	Months	Days	If less than one day
60	6	6	...hrs. ...min.

9. Birthplace: Frohheim, Norway
(Town, county, and state)

10. Usual occupation: cement finisher

11. Industry or business

FATHER
12. Name: Jabesh Jacobsen
13. Birthplace: Frohheim Norway

MOTHER
14. Maiden name: Olive unknown Jacobsen
15. Birthplace: Frohheim Norway

16. Informant: Russell M. C. Jacobsen
Address: Holly Wood Md

17. Disposition: Cremation (Burial, cremation, or removal. Which?) Date thereof: April 19 1945 (month) (day) (year)

Cemetery or crematory: Mt. Olive

Location: Chicago Ill

16. Funeral director: W. C. Mattingley Sons

Address: Leonardtown Md

19. 4/15/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 1945 at 10.25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11 1945 to April 15 1945 and that I last saw him alive on April 14 1945

Immediate cause of death	DURATION
Hemorrhage & exhaustion from a bad cut	
of amputation	4 days
Due to Cancerous of Stomach	12 Mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: F. F. Greenwell M. D. or other

Address: Leonardtown Date signed: 4-15-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04214

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:
County: St. Marys
City or town: Hollywood, (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give resideuce of mother)
State: Maryland County: St. Marys
City or town: Hollywood (rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ruby L. Jones

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 25th, 1939

8. AGE: Years	Months	Days	If less than one day
5	5	12	..... hrs. ..... min.

9. Birthplace: Hollywood, Maryland
(Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: Thomas Jones
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie L. Ferguson
15. Birthplace: Maryland

16. Informant: Annie L. Jones
Address: Hollywood, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/16/45 (month) (day) (year)
Cemetery or crematory: Joy Chapel
Location: Hollywood,
18. Funeral director: P. B. Robinson
Address: Leonardtown, Md.

19. 4-16-1945 (Date rec'd by registrar)
J. Neary M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13th 1945 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 1945 to April 13 1945 and that I last saw h.. alive on April 13 1945

Immediate cause of death	DURATION
Lobar Pneumonia	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Neary M.D. M. D. or other
Address: Great Mills Md. Date signed 4-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on FILM No. G 95 JUN 5 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04215

Reg. Dist. No. 282

1. PLACE OF DEATH:
County: St. Marys
City or town: Rural (Great Mills)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Dispensary, NAS, Patuxent River, Maryland
How long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Minn. County: St. Louis
City or town: Duluth
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1839 Wallace Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: MC COY, Ruth Ann

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Wirth Mc Coy
6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): 15 June 1918

8. AGE: Years	Months	Days	If less than one day
26 -27-	9	23	....hrs. ....min.

9. Birthplace: Owatonna, Minn. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Harry C. Partrige
13. Birthplace: Wisconsin

MOTHER
14. Maiden name: Mabel Stensrud
15. Birthplace: Wisconsin

16. Informant: Husband
Address: USNTTR, Piney Point, Maryland

17. Transportation (Burial, cremation, or removal. Which?) Date thereof 4-10-45 (month) (day) (year)
Cemetery or crematory
Location: Owatonna, Minnesota

18. Funeral director: P. B. Robinson
Address: Leonardtown, Md.

19. 4/9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 April 1945 at 0859 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 April 1945 to 8 April 1945 and that I last saw h...er alive on 8 April 1945

Immediate cause of death	DURATION
Pulmonary Embolus	60 hrs.
Congestive Heart Failure	24 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Richard H. Driscoll

23. SIGNATURE: Richard H. Driscoll, Lt. (MC) USN M. D. or other
Address: Disp. NAS, Patuxent River Md. Date Signed: 4-9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

04216

Reg. Diat. No. 281

1. PLACE OF DEATH:

County St Marys

City or town Rural St Inigoes

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys

City or town Rural St Inigoes

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hattie Milburn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Married

6.(b) Name of husband or wife Charles Milburn

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Unknown 1887

8. AGE: Years 58 | Months unknown | Days | If less than one day ... hrs. ... min.

9. Birthplace St Inigoes Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name John Bennett

13. Birthplace Maryland

MOTHER 14. Maiden name Eliza Bennett

15. Birthplace Maryland

16. Informant Anna Brooks

Address St Inigoes Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 7 1945 (month) (day) (year)

Cemetery or crematory Mt Zion Cemetery

Location St Inigoes Md

18. Funeral director E. L. Robinson

Address Dameron Md

19. April 6 1945 (Date rec'd by registrar) J. J. Bean Md Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1945, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 1945, to April 5 1945

and that I last saw h... alive on April 3 1945

	DURATION
Immediate cause of death: Uraemia	3 days
Due to: Interstitial Nephritis	5 years
Due to:	
Other conditions: Epilepsy	34 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. J. Bean Md M. D. or other

Address Great Mills Md Date signed 4/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

04217

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County St Marys

City or town Leonardtown Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys Co

City or town Leonardtown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph B. Morning SJ

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, ~~married, widowed, or divorced~~
Male	White	

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30 - 1890

8. AGE: Years	Months	Days	If less than one day
55	—	—	hrs. min.

9. Birthplace Philadelphia (Town, county, and state)

10. Usual occupation Priest

11. Industry or business

FATHER 12. Name Unknown

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace Unknown

16. Informant John L. Gilpatrick SJ

Address Leonardtown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2 - 1945 (month) (day) (year)

Cemetery or crematory Georgetown University

Location Washington DC

18. Funeral director W. C. Mattingly & Son

Address Leonardtown Md

19. 4/30 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1945, at ? M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 1944, to April 30 1945

and that I last saw him alive on April 30 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank A. Carvalho M. D. or other

Address Leonardtown Date signed 4/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

04218

CERTIFICATE OF DEATH

Reg. Dist. No. 28 Y

1. PLACE OF DEATH:

County St Marys

City or town California Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, Institution, or street address where death occurred:

3 months

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys

City or town California Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Alberta Pilkerton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife John Edward Pilkerton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 15 1872

8. AGE: Years	Months	Days	If less than one day
72	8	11	..... hrs. ..... min.

9. Birthplace Hollywood St Marys Md (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER

12. Name Roland Russell

13. Birthplace St Marys co

MOTHER

14. Maiden name Anna Grace Russell

15. Birthplace St Marys co

16. Informant Mrs Doris Pennant

Address California Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 27 1945 (month) (day) (year)

Cemetery or crematory St Johns cemetery

Location Hollywood Md

18. Funeral director W. C. Mansfield Sons

Address Leonardtown Md

19. 4/25-45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1945 at 9.00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to April 25 1945

and that I last saw h.. alive on April 24 1945

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P J Bean M. D. or other

Address Mechanicsville Md Date signed 4/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04219

CERTIFICATE OF DEATH

Reg. Dist. No. 283

1. PLACE OF DEATH:
County: St. Marys
City or town: Leonardtown Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 hours.
Hospital, institution, or street address where death occurred:
St. Marys Hospital
How long in hospital or institution? 2 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME George Raymond Thomas Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Infant

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 6 - 1943.

8. AGE: Years	Months	Days	If less than one day
one	one	19	hrs. min.

9. Birthplace: St. Marys County. (Town, county, and state)
10. Usual occupation: —
11. Industry or business: —

FATHER
12. Name: George Raymond Thomas.
13. Birthplace: St. Marys County Md

MOTHER
14. Maiden name: Bertie Cecilia Bowen
15. Birthplace: St. Marys County Md.

18. Informant: Bertie Cecilia Bowen.
Address: Chaptico, St. Marys Co. Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 4/26/45 (month) (day) (year)
Cemetery or crematory: St Josephs Cemetary
Location: Morganza Maryland.

18. Funeral director: Hoske E. Welch
Address: Chaptico Md

19. Apr 25 1945 (Date rec'd by registrar) L. B. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1945, at 330 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 1945 to April 25 1945 and that I last saw him alive on April 25 1945

Immediate cause of death	DURATION
Bilateral Broncho-pneumonia	?
Due to: Influenza infection of respiratory tract.	?
Due to:	
Other conditions: None.	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Alexius C. Welch M.D.
M. D. or other
Address: Chaptico, Md. Date signed 4/25/45